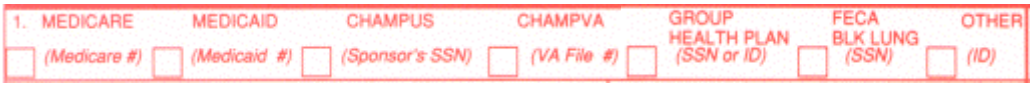
North Dakota Medicaid CMS-1500 Claim Form Billing Instructions

Medical Services
North Dakota Department of Human Services
600 E Boulevard Ave, Dept 325
Bismarck, ND 58505

January 2004

Block (1) PAYOR CODE:

Enter an X in the Medicaid box.

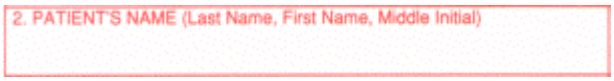


Block (1a) INSURED'S I.D. NUMBER:

This field is required. Enter the printed 9-digit North Dakota Medicaid Recipient Identification number shown on the eligibility card provided to recipients by Medical Services. The number must be entered without slashes, hyphens, or spaces. Do not enter the recipients Social Security Number as this is not accepted.

Block (2) PATIENT'S NAME:

This field is required. Enter the recipient name as it appears on the eligibility card provided to recipients by Medical Services. Enter the recipient name in Last Name, First Name, Middle Initial (if present) format. USE ALL CAPITAL LETTERS.

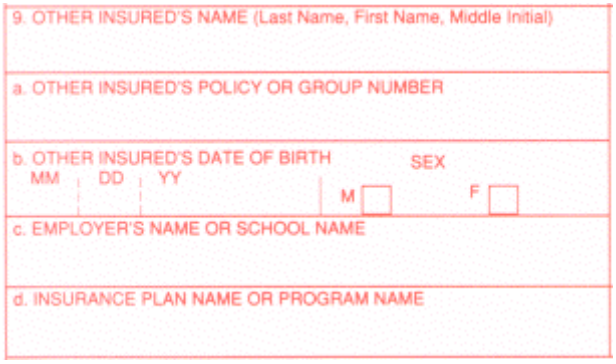


Block (3) PATIENT'S BIRTH DATE:

This field is required. Enter recipient's birth date in MMDDYY format and enter an 'X' in the appropriate box for the recipient's gender.

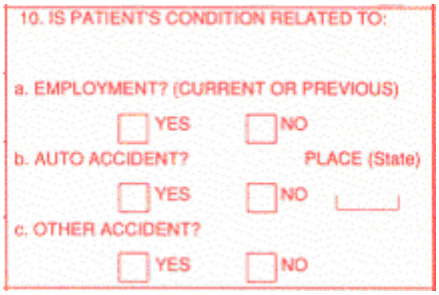
Block (9) OTHER INSURED'S NAME:

This field is required when applicable. If the recipient has other medical insurance coverage and he/she is not the policyholder (e.g., a child has coverage under a parent's policy), enter the policyholder's name and complete boxes 9a-9d. If no other insurance, leave 9-9d blank.



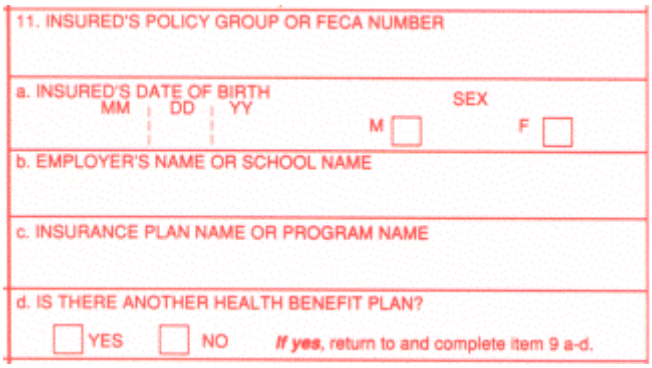
Block (10) IS PATIENT'S CONDITION RELATED TO:

This field is required when applicable. Enter an 'X' in all blocks that are applicable.



Block (11) INSURED'S POLICY GROUP OR FECA NUMBER:

This field is required when applicable. Enter an 'X' and/or information in all blocks that are applicable.



Block (17) NAME OF REFERRING PHYSICIAN OR OTHER SOURCE:

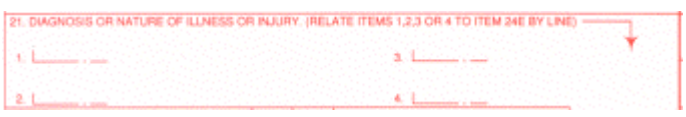
This field is required when applicable. Enter physician's name if applicable.

Block (17a) I.D. NUMBER OF REFERRING PHYSICIAN:

This field is required when applicable. Enter the physician's North Dakota Medicaid provider number or the physician's UPIN in this block if applicable.

Block (21) DIAGNOSIS OR NATURE OF ILLNESS OR INJURY:

This field is required. We require a medical diagnosis from the ICD-9-CM. Enter up to four ICD-9-CM diagnosis codes in descending order.

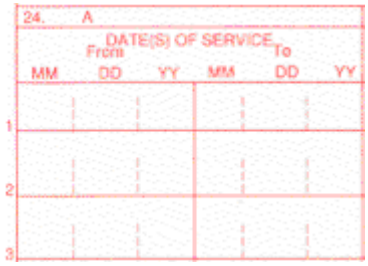


Block (23) PRIOR AUTHORIZATION NUMBER:

This field is required when applicable.

Block (24A) DATES OF SERVICE:

This field is required. Enter the 'From' date of service in the MMDDYY format. If services were provided for additional consecutive days you should complete the 'To' date column in the MMDDYY format.



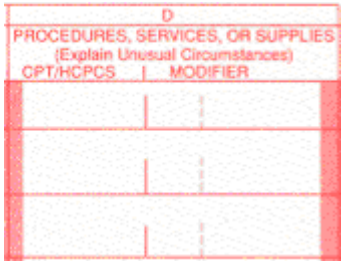
Block (24B) PLACE OF SERVICE:

This field is required. Enter the appropriate place of service code.

11 **Office**
12 **Home Inpatient Hospital**
22 **Outpatient Hospital**
23 **Emergency Room Hospital**
24 **Ambulatory Surgical Center**
31 **Skilled Nursing Facility**
54 **Intermediate Mental Health Care Facility**
81 **Independent Laboratory**
99 **Other Unlisted Facility**

Block (24D) PROCEDURE CODE:

This field is required. Enter the appropriate CPT/HCPCS code, including any applicable modifiers.



Block (24E) DIAGNOSIS CODE

Enter the appropriate number(s) (1, 2, 3, and/or 4) from Block 21 that correspond to the procedure/service on each line.

Block (24F) CHARGES

This field is required. Enter the usual and customary charge for the procedure/service in this block. Do not use dollar signs, decimals, or spaces. Providers are required to bill their usual and customary charge. The department captures this information to track payment levels. If a third party paid on the claim, enter the billed amount less any discounts or service benefit credits.

Block (24G) DAYS OR UNITS

This field is required. Enter the number of units for the procedure/service.

Block (24H) EPSDT/FAMILY PLAN

This field is required. This block is used to track Family Planning claims. Enter a 'Y' in this block if the service is a result of a Family Planning referral.

Block (24K) RESERVED FOR LOCAL USE

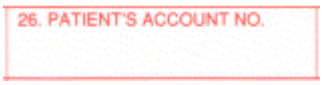
This field is required when applicable. If the billing provider in Block 33 is an *individual* practice, this block does not need to be filled out. If the billing provider in Block 33 is a *group* practice, you must enter the North Dakota Medicaid provider number or the UPIN of the provider who **rendered** the service.

Block (25) FEDERAL TAX I.D. NUMBER

This field is required. Enter the providers Federal Tax Identification number.

Block (26) PATIENT ACCOUNT NUMBER

This field is optional. The provider may enter their account number for the recipient. This number will be included on the remittance advice.



Block (28) TOTAL CHARGE

This field is required. Enter the sum of all charges on the claim. Do not use dollar signs, decimals, or spaces.

Block (29) AMOUNT PAID

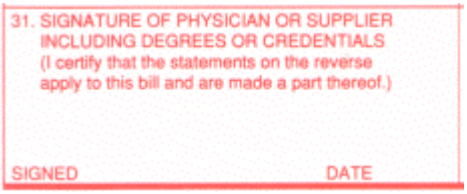
This field is required when applicable. If there is other insurance or another responsible party, the provider must collect from the other source of payment prior to billing North Dakota Medicaid. Attach a copy of the EOB (Explanation of Benefits) from the third party to the claim form. If a patient has court ordered coverage, the provider must collect from the source of the payment prior to billing North Dakota Medicaid. If there is no other insurance coverage indicated, the provider should leave this block blank. Do not enter copayments, prior NDMA payments, or recipient liability amounts.

Block (30) BALANCE DUE

This field is required. Enter the results of blocks (28) and (29). The Total Charges less Other Insurance = Balance Due. This is the amount the provider is requesting as payment from NDMA.

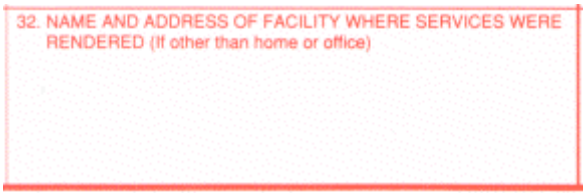
Block (31) SIGNATURE OF PROVIDER

This field is required. The provider or assigned representative must sign and date the claim in this block. By signing the claim, the provider agrees to and is certifying that the statements made by him/her are correct and justified. Signature stamps or computer-generated signatures are acceptable in conjunction with the signature on our provider enrollment form.



Block (32) NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED

This field is required when applicable. If services were provided somewhere other than the address listed in Block 33 or in the recipient's home, enter the facility name and address.



Block (33) PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE

This field is required. Enter the provider billing name and address. If the provider is an individual practice, enter the ND Medicaid Provider number in 'GRP#'. If the provider is a group practice, enter the group ND Medicaid Provider number in 'GRP#' and the performing physician in Block 24K.